

Vital Signs

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The Deadly Costs
of Health Inequality

Lee Humber

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1

Introduction

This is a book about health. It is an analysis of what health is and what it isn't. It offers an understanding of the nature of health inequality and why it exists. Centrally, *Vital Signs* contends that health is a complex phenomenon rooted in the conditions in which we live and in history. In order, therefore, to understand and address the unequal distribution of good health and long lives which characterises the twenty-first century, we need to know about and get to grips with the significance of the periods in history when health has improved. In *Vital Signs* I ask: what is at the core of health inequality and what does history tell us we can do about it?

Vital Signs joins a growing body of work casting a critical eye on the sorts of societies that have produced the current deepening health problems. When she retired in 2017, then director general of the World Health Organisation, Dr Margaret Chan Fung Fu-chun, said: 'The challenges facing health in the 21st century are unprecedented in their complexity and universal in their impact. Under the pressures of demographic ageing, rapid urbanization, and the globalized marketing of unhealthy products, chronic non-communicable diseases have overtaken infectious diseases as the leading killers worldwide.'¹ As public health experts Anne-Emanuelle Birn and Yogan Pillay added, Dr Chan failed to touch upon the: 'preventable disease, disability, and premature death related to poor living and working conditions, limited healthcare access, discrimination, and, ultimately, the gross inequities across population groups due to highly skewed distribution of wealth, power, and resources among the world's over 7.5 billion people.'²

Between them Chan, Birn and Pillay clearly illustrate where the health debate and global health agenda needs to focus in the twenty-first century. In 'rapid urbanisation' Chan references not only the global spread of cities but the poor and often squalid living conditions that exist within

them, affecting populations across not only the low- and middle-income countries (LMICs), but also areas and whole regions of the higher income countries (HICs), including swathes of the European Union, the US, China and Australasia. This is not simply a set of economic, social and political inequalities that exist between countries, these same inequalities in health exist within countries and within cities themselves as the work of authors such as Danny Dorling, Kate Pickett and others continues to expose. In the ‘highly skewed distribution of wealth’, Birn and Pillay point to the inequity and inequality that has become central to the critical analysis of global health over the last decades with a general acceptance among academics that health inequalities are linked to wealth inequality and represent a clear and present danger to the continuance of democratic societies as we have known them since the end of World War II. This same and ever-widening experience of inequality shapes the nature of disability, illness and disease such that by less than two decades into the new millennium non-communicable disease – by which Dr Chan means disease governed by the social and political environments in which we live – is the main source of premature death, shorter life expectancy and lives lived with disability. Today, the societies and environments we’ve built are humankind’s main life-threatening enemies. To try and understand the nature of this problem and to suggest possible solutions, *Vital Signs* provides an analytical framework, based on a critical reading of health-related history and ideas. Before I do that, however, it is important to establish some broad definitions of some of the major themes, terms and institutions which will inform this critical analysis. Throughout, I refer both to broad concepts of health and to ‘healthcare’. By healthcare I mean the organisation and provision of medical and social care to individuals or communities. On rare occasions in the book I focus solely on social care in order to develop analysis. The rest of the time I include health services and social care services in the term ‘healthcare’.

What do we understand by the term health? Despite the fact that in many senses a biomedical understanding of health has dominated the topic, with its view of health as largely the relationship between human biology and the natural world, there is no consensus on the definitions of what health actually is, even though the concept is central not only in medicine but also in the health social sciences (e.g. medical sociology, health psychology and medical demography). This may seem strange,

given the long history of medicine. Concepts of health are multidimensional and complex. For instance, Larson³ observed that disagreements about the meaning of health are common because health is imbued with political, medical, social, economic and spiritual components. Early definitions of health focused primarily on the body's ability to function. Health was seen as a state of 'normal' function that could be disrupted by disease. An example of such a definition of health is: 'a state characterized by anatomic, physiologic, and psychological integrity; ability to perform personally valued family, work, and community roles; ability to deal with physical, biological, psychological, and social stress'.⁴ Even here we see health as coterminous with what it enables us to do, and the roles it enables us to perform. Health, then, is pre-eminently a social phenomenon.

In 1948, in a radical departure from previous definitions and with the establishment of the World Health Organisation (WHO), a new definition linking health to a continual process of well-being was proposed. This definition understands health as resulting from changing relationships between 'physical, mental, and social well-being, and not merely the absence of disease and infirmity'.⁵ The medical establishment, with its traditional and narrower focus on the body's relationship with disease only, remain suspicious of attempts to develop new definitions. For years following 1948, WHO's proposals were set aside as an impractical ideal.

New approaches to health began to gain purchase as late as the 1980s, with keynote documents like the Ottawa Charter of 1986 beginning to affect public and professional opinion. Following Ottawa, health began to be seen as a 'resource for living', a much more positive approach than previous absence of disease interpretations. For many, health began to be understood in a much more holistic way as 'the extent to which an individual or group is able to realize aspirations and satisfy needs and to change or cope with the environment. Health is a resource for everyday life, not the objective of living; it is a positive concept, emphasizing social and personal resources, as well as physical capacities'.⁶ Aspects of health hitherto ignored were considered. Mental, intellectual, emotional and social health referred to a person's ability to handle stress, to acquire skills, to maintain relationships, all of which form resources for resiliency and independent living. In this view, health is an evolving relationship with all aspects of the environment – natural, social and political. In

focusing in on the individual's – or group's – ability to 'cope with the environment' this definition highlights the impact upon us of the world in which we live. This was a clear move away from biomedical concepts of health based on individualised struggles between individual bodies and disease. Instead, health can be understood as a relational process between humans and their societies. This definition opens the door to an approach which sees health as socially determined. In order to ensure the best of health, we need to ensure the best of societies that are most supportive of the health of all. Following Ottawa, health begins to reveal itself in its true form, as an ongoing collective and political struggle against those aspects of society that threaten and undermine it.

A specifically social model of health was developed to its clearest formulation early on by the sociologist Talcott Parsons (1902–79). He defines health as 'the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized'.⁷ Health in this sociological sense is more inclined towards the capacity of humans to fulfil their obligations, participate in social activities (including work) and fulfil role expectations in society in the face of structural limitations. Although 'role theory' has now largely been discredited,⁸ Parsons' analysis of the sociological space for health remains important and continues to inspire others.⁹

The salutogenic health model, developed by sociologist Aaron Antonovsky, can be considered a variant of this sociologically-based approach. Salutogenesis is a term coined by Antonovsky which describes an approach focusing on factors that support human health and well-being, rather than on factors that cause disease (pathogenesis). More specifically, the 'salutogenic model' is concerned with the relationship between health, stress and coping. Antonovsky's theories reject the 'traditional medical-model dichotomy separating health and illness'. Instead he describes the relationship as a continuous variable, what he called the 'health-ease versus dis-ease continuum'.¹⁰ The work of French philosopher Georges Canguilhem is another insightful approach, offering a historically based analysis of the relationship between 'normal' and ill health. His brilliant critique, 'The Normal and the Pathological', shows that a fixed state of something called 'normal' health is not possible and that the concept normal itself is a relational process, an idea taken up more broadly in sociology. Canguilhem demonstrates how the ideas of the normal and the pathological, far from being scientifically determined

and static, are value concepts shaped by political, economic and technological values linked to institutional power: 'A norm draws its meaning, function and value from the fact of the existence, outside itself, of what does not meet the requirement it serves. The normal is not a static or peaceful, but dynamic and polemical concept.'¹¹ For Canguilhem, the concept of 'normal' – including the idea of 'normal' health – serves specific ideological and political functions at specific points in history. His insights continue to provide a basis for critiquing the biomedical assumptions and methodologies that continue to dominate how we view health.

Before we look in more detail at the health inequality academic literature it is worth sketching out some of the major developments at the institutional, policy and programme levels that have influenced health inequality. WHO, a specialised agency of the United Nations specifically concerned with public health, came into being in 1948. It is responsible for key publications like the *World Health Report* and the worldwide *Health Survey*, and World Health Day. Historically, its roots are in the sanitation movements of the mid-nineteenth century. Between 1851 and 1938 a series of International Sanitary Conferences worked to combat diseases such as yellow fever and bubonic plague. The movement's major success came following the conference of 1892 when measures to combat 'King Cholera', the nineteenth century's most lethal infectious disease, were internationally recognised. Taking its modern form in 1948, WHO has been involved with numerous health initiatives including those against smallpox in the 1960s and HIV/AIDS in the 1980s. Its core objectives include such functions as acting as the directing and coordinating body for international health work, and establishing and maintaining effective collaboration with the United Nations, specialised agencies, governmental health administrations, professional groups and other organisations. Since the beginning of our current century a key growth area for the organisation in regard to collaborations has been via so-called public-private partnerships (PPP), a topic discussed in detail in Chapter 9. Keynote documents, programmes and declarations of intent that WHO has spearheaded include the Jakarta Declaration of 1997, the Bangkok Charter of 2005 and before those, the Ottawa Charter for Health Promotion of 1986, which established five key areas for health promotion that are still largely dominant today. These include building healthy public policy, creating supportive environments, strengthening

community action, developing personal skills and reorienting healthcare services towards prevention of illness and promotion of health. As this shows, WHO's role centres on initiating and collecting research and finding ways of putting findings into action.

Preceding the Ottawa Charter was the Alma-Ata Declaration, passed at the International Conference on Primary Health Care held in Kazakhstan in 1978. It expressed the need for urgent action by all governments, all health and development workers, and the world community in developing primary healthcare to protect and promote the health of all people. It was the first international declaration underlining the importance of primary healthcare. Primary healthcare includes that provided in communities as a first port of call through doctors, community clinics and so on. The centrality of the primary healthcare approach has since been accepted in principle by member countries of WHO. The Alma-Ata Declaration is a major milestone in the field of public health, identifying primary healthcare as the key area in pursuit of the global goal of 'Health for All'.

WHO has two main sources of funding. First, its member states pay assessed contributions (calculated relative to a country's wealth and population), which, since 2006, make up around 25 per cent of WHO's revenues.¹² The rest comes from voluntary contributions. For the two-year budget period 2010–11, 53 per cent of the voluntary contributions came directly from governments that for various reasons chose to go beyond their annual dues; 21 per cent came from other UN bodies (such as UNICEF, UNDP and UNAIDS) and other multilateral bodies (such as the Global Alliance for Vaccines and Immunization); and 18 per cent came from philanthropic foundations, such as the Bill & Melinda Gates Foundation (BMGF), the UN Foundation and the Rockefeller Foundation. It has been argued that partnerships with so-called 'philanthrocapitalism' like BMGF and the Rockefeller Foundation, along with relationships with 'big pharma' via the Global Alliance for Vaccines, leave WHO open to manipulation by private for-profit interests, an accusation that WHO strenuously denies.¹³ There can be little doubt, however, that the increasing influence of private companies via the extension of PPP relationships has impacted upon WHO's role. Working with any partner, including private business, necessarily means compromise, as I show below.

The Health Inequality Literature

In a paper published in 2015, Kate Pickett and Richard Wilkinson identified in excess of 140 research papers published over the recent past detailing the many and varied relationships between wealth inequality and health. As the authors say, ‘The body of evidence strongly suggests that income inequality affects population health and wellbeing ... large income differences have damaging health and social consequences ... and in most countries inequality is increasing’.¹⁴ Pickett and Wilkinson have been at the centre of this field of study since the publication of their groundbreaking study, *The Spirit Level: Why More Equal Societies Almost Always Do Better*,¹⁵ in 2009. In brief, the book argues that inequality, and in particular income inequality, impacts on the health of whole populations, ‘eroding trust, increasing anxiety and illness, [and] encouraging excessive consumption’. For the authors inequality is bad for everyone, not just those at the poorer end of the income continuum. It claims that across a range of different health and social problems including physical and mental health, drug abuse, education, imprisonment, obesity, social mobility, trust and community life, violence, teenage pregnancies and child well-being, outcomes are significantly worse in more unequal countries. The bigger the wealth gap, the worse the average health of the whole population, not just the poor. The book sold hundreds of thousands of copies globally, being translated into dozens of languages. Their follow-up book, *The Inner Level*, published in 2018, looks at the more personal, individual effects of inequality.¹⁶ As Wilkinson says of the book:

It takes a whole argument and evidence about the effects of inequality to a deeper and more intimate level. In ‘The Spirit Level’ we were dealing with things about society ‘out there’ – the size of the prison population, homicide rates, obesity rates and so on. But this takes it into the sphere of our social fears and anxieties ... Worries about self-worth: all the things that make social contact sometimes seem rather awkward and stressful.¹⁷

In large part underpinning the approach taken by these authors is the pioneering and continuing work and influence of Michael Marmot. Marmot has become one of the lynchpins in the global health debates

around inequality. Currently director of the University College London Institute of Health Equity, as well as a range of other influential roles, Marmot has led research groups on health inequalities for over 35 years. He was chair of the Commission on Social Determinants of Health (CSDH), which was set up by the World Health Organization in 2005, and produced 'Closing the Gap in a Generation'¹⁸ in August 2008 which I analyse in Chapters 4 and 9. He leads the English Longitudinal Study of Ageing, and is engaged in several international research efforts on the social determinants of health. He served as president of the British Medical Association (BMA) from 2010 to 2011. In the UK one of the most influential studies in which he was involved was the series of 'Whitehall Studies' of British civil servants, focusing on heart and other disease patterns.¹⁹ Phase one of the Whitehall Study examined over 18,000 male civil servants between the ages of 20 and 64, and was conducted over a period of ten years, beginning in 1967. A second phase was conducted from 1985 to 1988 and examined the health of 10,308 civil servants aged 35 to 55, of whom two-thirds were men and one-third women.²⁰

The studies found a strong association between grade levels of civil servant employment and mortality rates from a range of causes: the lower the grade, the higher the mortality rate. Men in the lowest grade (messengers, doorkeepers, etc.) had a mortality rate three times higher than that of men in the highest grade (administrators). This effect has since been observed in other studies and named the 'status syndrome'.²¹ For Marmot and his co-researchers, autonomy, a sense of control over your life and social connectedness – the supporting social networks on which individuals can draw, rather than financial resources, living and employment conditions or access to medical services, have the greatest impact on your health and life expectancy. Marmot went on to develop this idea further in his book, *Status Syndrome*, published in 2006. As Marmot writes: 'The lower in hierarchy you are, the less likely it is that you will have full control over your life and opportunities for full social participation ... Autonomy and social participation are so important for health that their lack leads to deterioration in health.'²² This idea – that the key influence on the differing health expectations of a population are to do with social status – is a dominant one in the inequality literature and one I critique in detail in Chapter 5.

The social geographer Danny Dorling's body of work is extensive, impressive and highly influential, particularly (but not only) with regard

to health inequality in the UK. Dorling has been writing on inequalities since the mid-1990s and has established himself as a major commentator on a wide range of topics, from health inequality to social justice more generally. His 2018 book, *Peak Inequality: Britain's Ticking Time Bomb*,²³ explores how health inequality fits into wider political debates ranging from those concerned with the condition and future of education and education systems in the UK and beyond, to the Brexit saga in the UK between 2018 and 2019. The final section of his book, 'Future', reads like a manifesto for an incoming reformist party, offering a wide range of stimulating ideas ending with the paper, 'Why Corbyn's Moral Clarity Could Propel Him to Number 10'.²⁴

Writing with Kate Pickett, Dorling provides a very useful critique of *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England*, better known as 'The Marmot Review', published in 2010.²⁵ Like other enquiries into UK health and health inequalities the report was commissioned by one political party in power and came to publication as another took over. *The Black Report*,²⁶ for example, was similarly commissioned by a Labour government and came to publication under a Conservative one. As Dorling and Pickett point out, this has meant that very few of the recommendations made by the report have been enacted. There is a political problem with *Fair Society* then. As the authors point out, there are methodological problems too. For example, Dorling and Pickett argue that the report fails to address inequalities at 'the top end of the social hierarchy, as well as at the bottom ... there is no suggestion that a maximum income or a constraint on the ratio of top-to-bottom incomes' should be made and acted upon.²⁷ Comparison is made between the recommendations made in *Fair Society* and those made by the *Black Report*, nearly 40 years previously. Ideas in *Fair Society* like 'Give every child the best start in life' and 'Create fair employment and good work for all' are, the authors believe, 'unlikely to scare the horses'²⁸ in government. Compare that to recommendation seven, for example, of the *Black Report* which details: 'We recommend that school health statistics should routinely provide, in relation to occupational class, the results of tests of hearing, vision and measures of height and weight. As a first step we recommend that local health authorities, in consultation with educational authorities, select a representative sample of schools in which assessments on a routine basis be initiated.'²⁹ The *Black Report* is a micro analysis and set of practical and practicable suggestions based

on a class analysis of health inequalities, while for Dorling and Pickett, Marmot's review is not.

In an earlier work, *Unequal Health*, Dorling focuses on some of the more conceptual issues surrounding the health inequality debate, in the process mounting a somewhat hesitant defence of the so-called 'inequality thesis' pioneered by Wilkinson and Pickett:

Grand theories such as the inequality thesis are currently out of vogue in an academia where the fashion of the day is to say everything is all very complicated and contingent. Grand theories are, by their nature, unlikely to be true. That is because they tend to contradict each other so only a few can hold water ... However, a grand theory may be proposed that turns out largely to appear to hold water.³⁰

I look in detail at the inequality thesis in Chapter 5.

The predominant feature of debate about health and healthcare services globally over the course of the twenty-first century is the increasing privatisation of provision, with services previously run as a public good by the governments of nation states being taken over, wholesale or in parts, by private healthcare providers. Chapter 2 uses the case study of developments in the UK to discuss this at length, but this tendency is far from a UK issue only. Privatisation in its various guises is 'spreading across Europe's health services like a rash', writes John Lister of Keep Our NHS Public and Health Campaigns Together (see Figure 1.1). EU member states' health systems are split between those based on employment-related health insurance and those financed centrally via general taxation. Both have been subject to political and policy pressures, including from EU-level, supportive of a growing role for private sector companies in this traditionally public service.³¹

Vital Signs is organised into two halves. The first half explores the nature of the health problem, looking at the current dominant paradigm in healthcare and with regard to health philosophies today, one based on the idea that healthcare and health generally are commodities to be bought and sold on a market in health. Chapters 2 and 3 examine how this paradigm is being and has been established, using the UK and the US healthcare systems as case studies. Chapters 4 and 5 compare and contrast two ways of understanding health problems currently. The first is a social determinant approach to health which points to how